Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
RYAN POTTER, MD

Respondent Name
FIDELITY & GUARANTY INSURANCE COMPANY

MFDR Tracking Number
M4-07-0710-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 2, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The insurance carrier failed to respond to the request for reconsideration. . . . A non-response from the insurance carrier is considered a denial."

Amount in Dispute: $243.92

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The insurance carrier did not submit a response for consideration in this review.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 24, 2006	Professional Medical Services and Supplies	$243.92	$243.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out the fee guideline for professional medical services.
3. 28 Texas Administrative Code §134.1 sets forth general provisions related to use of the fee guidelines.
4. Texas Labor Code §413.011 sets forth provisions regarding reimbursement policies and guidelines.
5. No explanations of benefits or documentation of the insurance carrier's reasons for denial or reduction of payment for the disputed services was presented for review.
6. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged received on October 9, 2006. The Division placed an additional notice to respond in the insurance carrier's Austin representative box, acknowledged received on February 26, 2007. Per former Division rule at 28 Texas Administrative Code §133.307(i), effective January 1, 2003, 27 *Texas Register* 12282, "Timeliness of Response. A respondent who fails to timely file a response waives the right to respond. The commission shall deem a response to be filed on the date the division receives a response. If the respondent does not respond timely, the commission shall issue a decision based on the request. The response will be considered timely if received by the commission within 14 days after the date the respondent

received the copy of the requestor's additional documentation." The insurance carrier did not submit any response for consideration in this review. Accordingly, the Division finds that the respondent has waived the right to respond; therefore, this decision is based on the request.

Issues

1. Did the respondent support the insurance carrier's reasons for denial of payment for the disputed services?
2. What is the recommended reimbursement for the medical services?
3. What is the recommended reimbursement the medical supplies?
4. Is the requestor entitled to reimbursement?

Findings

1. No information was presented to support the insurance carrier's reasons for reduction or denial of payment for the disputed services. The disputed services will therefore be considered per applicable Division rules and fee guidelines.
2. This dispute relates to professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.202(b), effective January 5, 2003, 27 *Texas Register* 4048 and 12304, which requires that "For coding, billing, reporting, and reimbursement of professional medical services, Texas Workers' Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." §134.202(c) further requires that "To determine the maximum allowable reimbursements (MARs) for professional services system participants shall apply the Medicare payment policies with the following minimal modifications: (1) for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%." Reimbursement for the professional services are calculated as follows:
   - Procedure code 20610, service date March 24, 2006, has a Medicare payment rate of $65.83. This amount multiplied by 125% is $82.29.
   - Procedure code 76003, service date March 24, 2006, has a Medicare payment rate of $72.86. This amount multiplied by 125% is $91.08.
3. Per 28 Texas Administrative Code §134.202(c)(2), "for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L: (A) 125% of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (B) if the code has no published Medicare rate, 125% of the published Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J, for HCPCS; or (C) if neither paragraph (2)(A) nor (2)(B) of this section apply, then as calculated according to paragraph (6) of this subsection." §134.202(c)(6) further requires that "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." Additionally, per §134.202(d), "In all cases, reimbursement shall be the least of the: (1) MAR amount as established by this rule; (2) health care provider's usual and customary charge; or, (3) health care provider's workers' compensation negotiated and/or contracted amount that applies to the billed service(s)." No documentation was found to support any negotiated or contracted amount applicable to the disputed services. Reimbursement is calculated as follows:
   - Procedure code J0475, service date March 24, 2006, does not have a fee listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. However, review of the Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J finds that this code has a Texas Medicaid payment rate of $209.43. This amount multiplied by 125% is $261.79. The health care provider's usual and customary charge is $223.00. Per §134.202(d), the provider's charge is the least amount: therefore, $223.00 is recommended.
   - Procedure code J0735, service date March 24, 2006, does not have a fee listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. However, review of the Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J finds that this code has a Texas Medicaid payment rate of $50.37. This amount multiplied by 125% is $62.96. The health care provider's usual and customary charge is $60.00. Per §134.202(d), the provider's charge is the least amount: therefore, $60.00 is recommended.

- Procedure code J1885, service date March 24, 2006, does not have a fee listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. However, review of the Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J finds that this code has a Texas Medicaid payment rate of $3.35. This amount at 4 units multiplied by 125% is $16.75.
- Procedure code J2250, service date March 24, 2006, does not have a fee listed in the Medicare DMEPOS fee schedule, nor does it have a fee listed in the Texas Medicaid fee schedule. This code represents a product for which neither CMS nor the Division has established a relative value unit and/or a payment amount. No documentation was found to support that the carrier has assigned a relative value in accordance with §134.202(c)(6). Reimbursement is therefore calculated according to 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission." Review of the submitted information finds no documentation to support that payment of the amount sought would result in a fair and reasonable rate of reimbursement for the services in this dispute. The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1. Additional reimbursement is not recommended.
- Procedure code J3010, service date March 24, 2006, does not have a fee listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. However, review of the Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J finds that this code has a Texas Medicaid payment rate of $1.16. This amount multiplied by 125% is $1.45.
- Procedure code J3301, service date March 24, 2006, does not have a fee listed in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule. However, review of the Texas Medicaid Fee Schedule Durable Medical Equipment/Medical Supplies Report J finds that this code has a Texas Medicaid payment rate of $1.50. This amount at 8 units multiplied by 125% is $15.00.
- Procedure code J3490, service date March 24, 2006, does not have a fee listed in the Medicare DMEPOS fee schedule, nor does it have a fee listed in the Texas Medicaid fee schedule. This code represents a product for which neither CMS nor the Division has established a relative value unit and/or a payment amount. No documentation was found to support that the carrier has assigned a relative value in accordance with §134.202(c)(6). Reimbursement is therefore calculated according to 28 Texas Administrative Code §134.1(c), effective May 16, 2002, 27 *Texas Register* 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission." Review of the submitted information finds no documentation to support that payment of the amount sought would result in a fair and reasonable rate of reimbursement for the services in this dispute. The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1. Additional reimbursement is not recommended.

4. The total recommended reimbursement is $489.57. The insurance carrier paid $0.00. The requestor is seeking $243.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $243.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $243.92 plus applicable accrued interest per 28 Texas Administrative Code §134.803, and/or §134.130 if applicable, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	June 6, 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.